Department of Veterans Affairs
Office of Inspector General
May 2015 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General Tells House Committee on Veterans' Affairs Subcommittee That VA's Purchase Card Program Is at Risk for Waste, Fraud, and Abuse

Linda A. Halliday, Assistant Inspector General (AIG) for Audits and Evaluations, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, concerning the Office of Inspector General's (OIG) work related to VA's Purchase Card Program. Ms. Halliday told the Committee that the number of VA's purchase card transactions is voluminous, the value represents significant financial expenditures, and that overall the OIG considers VA's Purchase Card Program at medium risk for waste, fraud, and abuse. She stated that the OIG's fiscal year 2015 risk assessment of VA's Purchase Card Program identified seven areas of high-risk practices that the OIG will continue to target for oversight. She also discussed recent OIG reports that identified significant control weaknesses that did not prevent transactions involving unauthorized commitments, improper payments, split purchases, and purchases that lacked appropriate supporting documentation, and noted that VA must significantly strengthen internal controls to prevent further misuse of taxpayer dollars intended to serve veterans and their families. Ms. Halliday was accompanied by Mr. Quentin G. Aucoin, Deputy AIG for Investigations (Field Operations), Mr. Kent Wrathall, Director, Atlanta Office of Audits and Evaluations, and Mr. Murray Leigh, Director, Financial Integrity Division, Office of Audits and Evaluations. [Click here to access testimony.]

ADMINISTRATIVE INVESTIGATIONS

OIG Finds Philadelphia VA Regional Office Official Misused Position for Private Gain of Subordinate and Spouse, Invited Staff to Home for Psychic Readings

The Assistant Director, Philadelphia VA Regional Office (VARO), while as the Acting Director, misused her position for the private gain of a subordinate and his spouse, misused her title to endorse the private enterprise, and invited subordinates to her home to take part in psychic readings. OIG also found that she had a less-than-arm's-length relationship with subordinates whom she characterized as friends. As a senior leader, she is held to a higher standard and should set the tone for her subordinates to follow, and establishing personal relationships with a select group of employees within her chain of authority gives the appearance of preference for those few employees. Although OIG found no actual preference, just the appearance of preference diminishes her position and authority as a senior leader. Further, OIG found that the Manager of the Pension Management Center (PMC), failed to report his spouse's income on his 2013 and 2014 Confidential Financial Disclosure Reports, Office of Government Ethics Form 450, which he certified as true, complete, and correct. OIG made a criminal referral of the false statements to the U.S. Department of Justice, but they declined to criminally prosecute in favor of administrative actions. The PMC Manager also failed to

claim that same financial gain on his and his spouse's income tax returns. OIG referred the failure to report income to the Internal Revenue Service and the Pennsylvania State Department of Revenue. [Click here to access report.]

OIG REPORTS

Annual Federal Information Security Management Act Audit Shows VA Still Faces Challenges Implementing Its Information Security Risk Management Program

The Federal Information Security Management Act (FISMA) requires agency Inspectors General to annually assess the effectiveness of agency information security programs and practices. In fiscal year (FY 2014), the OIG audited VA's information security program to evaluate its compliance with FISMA requirements and applicable National Institute for Standards and Technology guidelines. VA has made progress developing policies and procedures but still faces challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. While some improvements were noted, this FISMA audit continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems. Weaknesses in access and configuration management controls resulted from VA not fully implementing security standards on all servers, databases, and network devices. VA also has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, database, and server platforms VA-wide. Further, VA has not remediated approximately 9,000 outstanding system security risks in its corresponding Plans of Action and Milestones to improve its information security posture. As a result, the FY 2014 consolidated financial statement audit concluded that a material weakness still exists in VA's information security program. OIG recommended the Executive in Charge for Information and Technology implement comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems. [Click here to access report.]

VA Did Not Comply With Two of Six Improper Payments Elimination and Recovery Act Requirements, Five Programs Did Not Meet Improper Payment Reduction Targets

OIG conducted the FY 2014 review to determine whether VA complied with the requirements of the Improper Payments Elimination and Recovery Act (IPERA). VA reported improper payment estimates totaling approximately $1.6 billion in its FY 2014 Performance and Accountability Report (PAR) compared with $1.1 billion in its FY 2013 PAR. The increase was due primarily to higher estimated improper payments for the Compensation and Pension programs under the Veterans Benefits Administration (VBA). VA did not comply with two of six IPERA requirements for FY 2014. VBA reported four programs that did not meet its reduction targets. The Veterans Health Administration (VHA) also reported a missed target for one program. Further, VBA did not meet the requirement to publish an improper payment estimate for one program because the estimate was not considered reliable. Additionally, VA's risk assessments should incorporate a stronger consideration of contracting risk. VBA and VHA should make improvements in their sample evaluation procedures. VBA's Compensation program crossed an Office of Management and Budget threshold for

potential designation as a high-priority program due to OIG's review identifying additional improper payments within the sample transactions. Thus, OIG increased the projection of the potential improper payment in VBA's Compensation program. [Click here to access report.]

Review Finds Failure To Timely Diagnose and Treat Patient's Lung Cancer at Martinsburg, West Virginia, VA Medical Center

OIG conducted an inspection to determine the validity of allegations regarding physician leaders' mismanagement and abuse of power at the Martinsburg VA Medical Center (the facility), Martinsburg, WV. OIG did not substantiate the allegations that physician leaders overlooked the medical neglect of a patient, denied transfer of critically ill patients, disregarded specialists' opinions, and gave a nurse authority to delay procedures without informing responsible specialists. However, during the course of OIG's review and separate from the original allegation, OIG found that the facility failed to provide timely diagnosis and treatment of a patient's lung cancer. In addition, the facility did not pursue all required administrative procedures in this case. OIG recommended that the Facility Director ensure that the facility: (1) comply with VHA and facility test results notification requirements, (2) strengthen the root cause analysis process, (3) evaluate the care of the subject patient with Regional Counsel for possible disclosure(s) to the surviving family member(s) of the patient, and (4) strengthen and monitor the peer review process. The Veterans Integrated Service Network and Facility Directors concurred with OIG's recommendations and provided acceptable action plans. [Click here to access report.]

Results for Inspection of Indianapolis, Indiana, VARO

Overall, OIG benefits inspectors found that the Indianapolis, IN, VARO staff incorrectly processed 18 of the 87 (21 percent) disability claims processed. The claims processing errors resulted in approximately $188,000 in improper benefits payments from October 2009 until September 2014. The OIG benefits inspectors sampled claims considered at increased risk of processing errors; these results do not represent the accuracy of all disability claims processing at this VARO. During this benefits inspection, OIG staff found VARO staff incorrectly processed 13 of 30 claims related to temporary 100 percent disability evaluations. In 10 of these cases, VARO staff delayed scheduling the required VA medical reexaminations despite receiving reminder notifications to do so. VARO staff accurately processed 26 of the 27 traumatic brain injury claims OIG sampled—demonstrating improvement from the OIG inspection in 2011 where 4 of the 20 sample cases contained errors. Thus, OIG determined the VARO's actions in response to the previous inspection recommendations have been effective. However, 4 of the 30 sample cases reviewed relating to Special Monthly Compensation and ancillary benefits contained processing errors. OIG inspectors also determined VARO staff followed policy and accurately established claims in VBA's electronic system of records using correct dates of claims for the 30 claims sampled. However, VARO staff delayed processing actions in 9 of the 30 benefits reduction cases resulting in over $57,000 in improper benefit payments from October 2013 until September 2014 because management considered other work to be a higher priority. The Director of the

Indianapolis VARO concurred with OIG's recommendations for improvement. [Click here to access report.]

Results for Inspection of Pittsburgh, Pennsylvania, VARO
Overall, OIG benefits inspectors found Pittsburgh, PA, VARO staff incorrectly processed 10 of the 84 (12 percent) disability claims OIG reviewed. The claims processing errors resulted in approximately $496,000 in improper benefits payments from February 2008 until September 2014. The OIG benefits inspectors sampled claims considered at increased risk of processing errors. These results do not represent the accuracy of all disability claims processing at this VARO, however, accountability for public resources is not reasonably assured without timely and accurate actions. During this benefits inspection, OIG staff found VARO staff incorrectly processed 8 of 30 claims related to temporary 100 percent disability evaluations but found all 30 traumatic brain injury claims were processed correctly. OIG noted significant improvement in these two areas since its last review in 2011. Pittsburgh VARO staff generally processed Special Monthly Compensation and ancillary benefits claims accurately, with OIG noting 2 of the 24 cases sampled contained processing errors. OIG inspectors also determined VARO staff generally followed policy and accurately established claims in VBA's electronic system of records using correct dates of claims for 28 of the 30 claims sampled. However, VARO staff delayed processing actions in 5 of the 16 benefits reduction cases resulting in approximately $42,000 in improper benefit payments from January 2013 until July 2014. The Director of the Pittsburgh VARO concurred with OIG's recommendations for improvement. [Click here to access report.]

Combined Assessment Program Reviews
In May 2015, OIG published three Combined Assessment Program (CAP) reviews containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following nine activities: (1) Quality Management, (2) Medication Management, (3) Coordination of Care, (4) Magnetic Resonance Imaging (MRI) Safety, (5) Acute Ischemic Stroke Care, (6) Mental Health Residential Rehabilitation Treatment Program, (7) Emergency Airway Management, (8) Environment of Care, and (9) Surgical Complexity.
VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
VA St. Louis Health Care System, St. Louis, Missouri
William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina

Community Based Outpatient Clinic Reviews
In May 2015, OIG published six Community Based Outpatient Clinic (CBOC) reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate four operational activities: (1) Environment of Care, (2) Alcohol Use Disorder, (3) Human Immunodeficiency Virus (HIV) Screening, and (4) Outpatient Documentation.
VA Roseburg Healthcare System, Roseburg, Oregon

VA Palo Alto Health Care System, Palo Alto, California
VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
VA Boston Healthcare System, Boston, Massachusetts
VA Puget Sound Health Care System, Seattle, Washington
Beckley VA Medical Center, Beckley, West Virginia

ADMINISTRATIVE CLOSURES

As a result of a review of OIG decision-making practices on closing reviews administratively, the Deputy Inspector General instituted a new policy requiring coordination of administrative closures within the Immediate Office of the Inspector General, the Office of the Counselor to the Inspector General, and the Release of Information Office. This process will ensure consistency in decision-making regarding when and how public release of related documents is handled. The Deputy Inspector General also directed a retrospective review of administrative closures by the Office of Healthcare Inspections from FY 2006 to present. Based on this review, OIG has published administrative closure reports on the OIG website, publishing the following two in May.

Healthcare Inspection – Alleged Violation of Patient Rights, Sheridan VA Health Care System, Sheridan, Wyoming
Healthcare Inspection – Consult Management Concerns, Central Arkansas Veterans Healthcare System, Little Rock, AR

CRIMINAL INVESTIGATIONS

OIG Investigation Results in Civil Settlement Agreement

An OIG investigation revealed that two co-owners of a California based Service-Disabled Veteran-Owned Small Business (SDVOSB) fraudulently secured approximately $30 million in VA set-aside contracts from the National Cemetery Administration (NCA). The veteran who was listed as the owner of the SDVOSB admitted that he was not in control of the company. Further investigation revealed that the non-veteran co-owner ran the business, which was similar to his former company that had previously been awarded several NCA contracts prior to 2007 (the year NCA contracts became designated as SDVOSB set-asides). The SDVOSB owners signed a Civil Settlement Agreement and agreed to pay VA $1 million.

Son of Disabled Veteran Indicted for Theft of Government Funds

The son of a disabled veteran was indicted for theft of Government funds after having been previously indicted for the same charge and aggravated identity theft. The most recent indictment is related to a $111,000 VA contract paid after the defendant's previous indictment and more than $34,000 paid after his arrest. A VA OIG, Army Criminal Investigation Command, Defense Criminal Investigative Services, General Services Administration (GSA) OIG, Social Security Administration (SSA) OIG, and Small Business Administration OIG investigation revealed that the defendant, using two separate businesses, obtained 15 SDVOSB contracts by using his father's identity and military record without his father's knowledge or consent (the father was not involved in

any way with either business). The defendant fraudulently certified both businesses as SDVOSBs through VA's Center for Veterans Enterprise and GSA's Central Contractor Registration/Online Representations and Certifications Application. As a result, the son was awarded 5 VA contracts and 10 U.S. Army and Air Force contracts. The 15 contracts totaled $2.7 million with the value of the VA contracts at $1 million.

Former Ann Arbor, Michigan, VA Canteen Chief Arrested for Theft of Government Funds
A former Ann Arbor, MI, VA canteen chief was arrested for theft of Government funds. A Canteen Service audit revealed a loss of over $400,000. During a subsequent OIG investigation, the defendant admitted to embezzling more than $150,000.

Veteran Arrested for Forcible Touching
A veteran was arrested for forcible touching after having been previously arrested for aggravated harassment. Both arrests involved the defendant's harassing behavior of a VA employee at the Buffalo, NY, Community Day Program Center.

Veteran Indicted for Making Threats to a Federal Official
A veteran was indicted for making threats to a Federal official. An OIG and VA Police Service investigation revealed that the veteran was seeking a certain procedure in a non-VA facility located in Florida, although the veteran was a resident of Vermont. VA did not find the veteran eligible for such a procedure, even within the VA system. After the veteran learned that the VA Medical Center (VAMC) denied the consult for the non-VA care, the veteran threatened the Chief of Staff and his family. Specific conditions of the veteran's release included home detention with a location monitoring bracelet and no contact with VA staff or property except through the VA Police Service and the emergency room.

Former VA Fiduciary Arrested for Wire Fraud and Theft of Government Funds
A former VA fiduciary was indicted and arrested for wire fraud and theft of Government funds. A VA OIG and SSA OIG investigation revealed that the defendant stole $259,563 of VA and SSA benefits from a disabled veteran. During the time the fiduciary embezzled the funds, he knew that the veteran lived in a state veteran's home. Gold and silver coins purchased with the stolen funds were recovered during a search of the defendant's residence.

Non-Veteran Sentenced for Identity Theft
A non-veteran was sentenced to 5 years' incarceration (suspended), 5 years' probation (to include random drug and alcohol screens), and ordered to pay VA restitution of $19,341 after pleading guilty to theft of identity, theft of services over $10,000, and theft by deception over $500. An OIG and state police investigation revealed that the defendant used his veteran brother's identity to obtain controlled substances, health care, and beneficiary travel payments from the Louisville, KY, VAMC.

Veteran Indicted for VA Compensation Fraud
A veteran was indicted for theft of Government funds. An OIG and SSA OIG investigation revealed that the defendant had been in receipt of VA compensation benefits and SSA benefits since 1997, claiming loss of use of both hands and feet due to Multiple Sclerosis. While allegedly suffering from his level of reported disability, the defendant lived an active lifestyle to include participating in a 2008 "Marine Corps Mud Run," playing adult league baseball from 2006 through 2012, working as both a personal fitness trainer and a weight trainer for a high school football team, and assisting with football games. Additionally, surveillance showed the defendant using a wheelchair during VA appointments and then ambulating without aids at area restaurants and bars. The loss to VA is $1,545,890, and the loss to SSA is $133,107.

Veteran Pleads Guilty to Theft of VA Benefits
A veteran pled guilty to theft after an OIG investigation revealed that he received VA benefits under two different claim numbers. The court ordered that the defendant pay VA restitution of $67,665 as part of the plea agreement. An OIG investigation revealed that VA funds for both claims were direct deposited into two separate accounts at different banks and that the funds were subsequently withdrawn from the accounts.

Mother of Two Minor VA Beneficiaries Indicted for Theft of Government Funds
The mother of two minor VA beneficiaries (children of a veteran) was indicted for theft of Government funds. An OIG investigation revealed that the defendant concealed her employment income and her children's Social Security income in order to continue to receive VA benefits. The loss to VA is $41,170.

Daughters of Deceased VA Beneficiaries Arrested for Theft
The daughter of a deceased VA beneficiary was arrested for theft and other charges. A VA OIG and SSA OIG investigation revealed that the defendant received, forged, and negotiated VA and SSA benefit checks issued after her mother's death in June 2005. The loss to VA is approximately $110,000, and the loss to SSA is approximately $63,000.

In a separate case, a daughter of a deceased VA widow beneficiary was arrested after being indicted for theft of Government funds. An OIG investigation revealed that this defendant stole VA Dependency and Indemnity Compensation benefits that were direct deposited after her mother's death in April 2007. This defendant was interviewed and confessed to the theft. Contrary to instructions, she subsequently withdrew additional funds from the account before they could be reclaimed. The loss to VA is $103,191.

Daughters of Deceased VA Beneficiaries Sentenced for Theft of VA Benefits
The daughter of a deceased VA widow beneficiary was sentenced to 2 years' incarceration, 5 years' probation, and ordered to pay VA $271,403 in restitution. A VA OIG and SSA OIG investigation revealed that the defendant stole VA benefits that were direct deposited to a joint account after her mother's death in March 1993.

In a separate case, a daughter of a deceased VA beneficiary was sentenced to 33 months' incarceration, 2 years' probation, and ordered to pay $143,403 in restitution to VA and SSA. A VA OIG and SSA OIG investigation revealed that this defendant stole VA and SSA benefits that were direct deposited to her mother's account after her death in December 2008. This defendant used the stolen funds for her personal expenses.

Widow of Deceased VA Beneficiary Indicted for Theft
The widow of a deceased VA beneficiary was indicted for theft of Government funds and false statements. An OIG investigation revealed that the defendant failed to notify VA of her 1995 remarriage and continued to receive VA Dependency and Indemnity Compensation benefits until July 2013. The defendant admitted to using the funds for her and her family's personal expenses. The loss to VA is approximately $126,000.

Former United Parcel Service Employee Sentenced for Theft of VA Drugs
A former United Parcel Service (UPS) employee was sentenced to 3 years' supervised probation, ordered to attend a substance abuse treatment program, and ordered to pay VA restitution of $1,390 after pleading guilty to theft of Government property. An OIG investigation revealed that between March 2011 and June 2012 the defendant stole VA controlled substances, specifically oxycodone, morphine, hydromorphone, and methadone, from 17 UPS packages.

Veteran Indicted for VA Travel Benefit Fraud
A veteran was indicted for theft after an OIG investigation revealed that for over 9 months he filed 115 false travel vouchers. The defendant claimed to have repeatedly travelled 224 miles roundtrip to attend his medical appointments; however, he was living less than 4 miles from the Spokane, WA, VAMC. The loss to VA is $10,877.

Richard J. Griffin
Deputy Inspector General